A GUIDE TO MEDICARE

Department of Health and Human Services

Health Care Financing Administration

July 1980

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GLOSSARY OF TERMS

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries — approximately 47 million of the nation's aged, disabled and poor The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

THE MEDICAID/MEDICARE MANAGEMENT INSTITUTE (M/MMI), within the Health Care Financing Administration, Bureau of Program Operations, works with Federal, State, and contractor staff toward improved management of the Medicaid and Medicare programs.

The M/MMI promotes program management improvements through problem analysis and technical assistance for corrective action, and fosters exchange of ideas and techniques through conferences, workshops, training and publications.

Health Care Financing Administration
Bureau of Program Operations
Medicaid/Medicare Management Institute

This booklet is designed to highlight the Medicare program, primarily for use by employees of the Health Care Financing Administration, the Social Security Administration, and by others involved in the administration of Medicare.

The information presented is not all inclusive and does not take the place of regulations, operating procedures, or manual instructions.

Health Care Financing Administration
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Medicaid/Medicare Management Institute

Two programs of health insurance protection

- **Hospital insurance—Part A**
  Covers hospitalization and related care

- **Medical insurance—Part B**
  Covers physicians' care and certain medical and other health services

Words **Capitalized** in **Bold Print** are defined in the **Glossary**

Part A—Hospital Insurance

People age 65 and older
and
Entitled to monthly
Social Security (SS) benefits
or
Railroad Retirement (RR)
annuity

or

People age 65 and older
and
Ineligible for SS or RR benefits
and
DEEMED INSURED
and
A U.S. resident
and
A U.S. citizen (or alien lawfully
admitted for
permanent residence with 5
years
continuous residence)
and

(See next page)

Part B—Medical Insurance

People entitled to Part A
or

People age 65 and older
and
A U.S. resident
and
A U.S. citizen (or alien lawfully
admitted for permanent
residence with 5 years
continuous residence)

- Most eligible people have **AUTOMATIC ENROLLMENT** in Part B unless they specifically decline

- Enrollment request necessary by person who:
  —is not already an SS or RR beneficiary
  or
  —has previously declined Part B Medical Insurance
  or

(See next page)

WHO CAN QUALIFY

WHO CAN QUALIFY

Part A—Hospital Insurance

Not covered and (with some exceptions) could not have been covered under Federal Employees' Health Benefits Act of 1959
Note **DEEMED INSURED** provision applies only to women who attained age 65 before 1974, and to men who attained age 65 before 1975

or

People age 65 and older
and
Enrolled in Part B
and
A U S resident
and
A U S Citizen (or alien lawfully admitted for permanent residence with 5 years continuous residence)
and
Not otherwise eligible
May voluntarily enroll in Part A (must pay a monthly premium — **PREMIUM HI**)

or

People under age 65
Entitled (or deemed entitled) to disability-based benefits for the 24 preceding months

or

(See next page)

Part B—Medical Insurance

—has terminated Part B Medical Insurance (voluntarily or involuntarily)

- Entitlement not retroactive (except for people with end-stage renal diseases (ESRD) or people for whom States pay the Part B premium under a **STATE BUY-IN AGREEMENT**)

Part A—Hospital Insurance

People any age
With end-stage renal disease (**ESRD**) requiring transplant or dialysis and either
(a) SS beneficiary or RR annuitant, or
(b) Fully or currently insured (railroad work may count), or
(c) Spouse or dependent child of (a) or (b)

- Application must be filed
- Retroactive for up to 12 months (except **PREMIUM HI**—no retroactivity)

WHO CAN QUALIFY

Part A—Hospital Insurance

Services are subject to review and certification for payment by the **PSRO** or an institutional **UTILIZATION REVIEW COMMITTEE**. The certification is based on the medical necessity, quality, and appropriateness of the care to the needs of the patient.

3 major services:

1. **Inpatient hospital care**
   Includes:

   - Up to 90 days per **BENEFIT PERIOD**
     (renewable in subsequent benefit periods)
     plus 60 days **LIFETIME RESERVE**
     (nonrenewable)
     in a **PARTICIPATING** hospital (and under limited conditions, in a nonparticipating U.S. hospital or a foreign hospital.)
   - Psychiatric hospital care (190 days lifetime limit with special reduction for first benefit period)
   - Semiprivate room and board
   - Operating room

(See next page)

Part B—Medical Insurance

Includes:

- Physicians' services
  (and services and supplies furnished incident to a physician's professional service)
- Outpatient hospital services:
  —incident to physicians' services
  —diagnostic and therapeutic services provided by a **PARTICIPATING** hospital
- Diagnostic tests
  —x-ray
  —clinical lab tests
  —other diagnostic tests
- Therapy
  —x-ray
  —radium
  —radioactive isotope
- Limited chiropractic services

(See next page)

WHAT IS COVERED

WHAT IS COVERED

PART A—Hospital Insurance

- Special care units
- Recovery room
- Drugs, medical supplies, and appliances furnished by the hospital
- Laboratory tests, x-ray, and radiological services
- Rehabilitation services
- Medical social services
- **EMERGENCY SERVICES** (can also be covered in nonparticipating hospitals under certain conditions)
- **FOREIGN SERVICES** (emergency and non-emergency inpatient care in Canada and Mexico may be covered under limited conditions)

(See next page)

Part B—Medical Insurance

- Certified **RURAL HEALTH CLINICS (RHC)** may furnish the following services
  - —physician services
  - —physician assistant services
  - —nurse practitioner services
  - —nurse midwife services
  - —part-time visiting nurse services to home bound patients in areas with a shortage of home health services
  - —services and supplies incident to the services of physicians, physician assistants, nurse practitioners and nurse midwives
- Other medical items and services
  - —surgical dressings
  - —splints
  - —casts
  - —other devices used for reduction of fractures and dislocations
- Durable medical equipment for use in patient's home (rental or purchase) including home dialysis equipment and supplies

(See next page)

Part A—Hospital Insurance

Excludes:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Personal comfort items
- Private duty nurses
- Physicians' services (may be covered under Part B)
- Private room (unless medically necessary)
- Noncovered **LEVEL OF CARE**

2. **Extendad care**
   Includes:
   - Up to 100 inpatient days in a **PARTICIPATING** skilled nursing facility **(SNF)** per **BENEFIT PERIOD**

(See next page)

Part B—Medical Insurance

- End-stage renal disease facility care by approved suppliers of maintenance dialysis services
- Certain ambulance services
- Prosthetic devices replacing all or part of an internal body organ (including prosthetic eyeglasses and contact lenses which replace the lens of the eye removed during cataract surgery)
- Braces for arm, leg, back, neck
- Artificial arms, legs, eyes
- Home health services—up to 100 visits in a calendar year, in addition to Part A visits (same requirements as Part A except prior hospitalization not required)
  (Visiting nurse services furnished by a **RHC** are not considered home health service visits and do not count against the 100 visits)

(See next page)

WHAT IS COVERED

WHAT IS COVERED

Part A—Hospital Insurance

- Semiprivate room and board
- Regular nursing services
- Drugs, medical supplies and appliances furnished by the **SNF**
- Therapy (physical, occupational, speech)
- Medical social services

Note: Admission to the **SNF** must follow within 14 days, a qualifying hospital stay of at least 3 consecutive days (the 14-day requirement may be extended under certain conditions)

Beneficiary must:

—Be admitted for further treatment of a condition treated in the hospital
—Require skilled nursing care or other skilled rehabilitation services on a daily basis
—which—
as a practical matter can only be provided in the **SNF** on an inpatient basis

(See next page)

Part B—Medical Insurance

- Outpatient physical therapy and speech pathology by a **PARTICIPATING** hospital **SNF HHA** or approved clinic rehabilitation agency or public health agency
- Coverage of services of independently practicing physical therapists (up to $100 of incurred expenses per calander year)

Excludes:

- Items and services not reasonable and necessary for diagnosis or treatment of illness or injury
- Routine physical check-ups
- Hearing aids, eyeglasses, and examinations for fitting or changing them (exception: eye prosthetic devices above) and refractive services
- Immunizations (except where immediate risk of infection)

(See next page)

Part A—Hospital Insurance

Excludes:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Personal comfort items
- Private duty nurses
- Physicians' services (may be covered under Part B)
- Private room (unless medically necessary)
- Noncovered **LEVEL OF CARE**

3. Home health services

Covered only if beneficiary:

- confined to home
- under care of physician
- under written home health plan established by physician within 14 days after discharge from hospital or **SNF**

(See next page)

Part B—Medical Insurance

- Cosmetic surgery
- Care, treatment, filling, removal or replacement of teeth
- Routine and certain other foot care
- Orthopedic shoes (unless built into leg braces) and other supportive devices for the feet
- Prescription drugs (except when not self-administered and cost included in administering physician's bill)

WHAT IS COVERED

WHAT IS COVERED

Part A—Hospital Insurance

- needs intermittent or part-time skilled nursing care or physical or speech therapy for condition for which inpatient hospital or extended care services were received
- is provided services within year following most recent discharge from 3-day hospital or covered **SNF** stay, whichever is later

Includes:

- Up to 100 visits from a **PARTICIPATING** home health agency (**HHA**) after start of one **BENEFIT PERIOD** and before start of next
- Part-time nursing care
- Therapy (physical, occupational, speech)
- Part-time services of home health aides
- Medical supplies and appliances furnished by the **HHA**
- Medical social services

(See next page)

Part A—Hospital Insurance

Excludes:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Full-time nursing care
- Drugs and biologicals
- Personal comfort items
- Meals delivered to the home
- Homemaker services
- Physicians' services (may be covered under Part B)
- Noncovered **LEVEL OF CARE**

NOTE: ALL MEDICARE COVERED SERVICES MAY BE PROVIDED TO A MEDICARE BENEFICIARY WHO IS A MEMBER OF A HEALTH MAINTENANCE ORGANIZATION (HMO) WHICH HAS A CONTRACT WITH HCFA. IN THIS CASE, NO CLAIM IS FILED. PAYMENT IS MADE TO THE HMO BASED ON THE COST OF PROVIDING THE SERVICE, AND THE DEDUCTIBLE AND COINSURANCE ARE MET THROUGH A REGULAR MONTHLY PREMIUM PAID BY THE BENEFICIARY TO THE HMO

WHAT IS COVERED

General Exclusions from Coverage

No payment can be made under either the hospital or medical insurance programs for certain items and services which are excluded under the Medicare law. These are items or services —

- For which the beneficiary has no legal obligation to pay and for which no other person has a legal obligation to provide or pay for
- Which are paid for by governmental entities—Federal, State, or local
- Which are required as a result of war
- For which charges are imposed by an immediate relative of the beneficiary or a member of his/her household
- For which payment has been made or can reasonably be expected to be made under a workers' compensation law

WHAT IS NOT COVERED

Part A—Hospital Insurance

- No monthly premium for insured beneficiaries
- Available with premium for uninsureds

Inpatient hospital care

Program pays **REASONABLE COSTS** after

- Inpatient hospital **DEDUCTIBLE** per **BENEFIT PERIOD**
  - —Amount determined each year by the Secretary of HHS
  - —Approximates the national average cost of a 1-day hospital stay
  - —Changes effective for benefit periods beginning on or after January 1
- **COINSURANCE** from 61st through 90th day
  - —Equals 1/4 of inpatient hospital deductible
- Coinsurance during **LIFETIME RESERVE**
  - —Equals 1/2 of inpatient hospital deductible
- Blood deductible—first 3 pints (or equivalent units of packed red blood cells) per benefit period (beneficiary has the option to replace this blood)

(See next page)

Part B—Medical Insurance

- Monthly premium (may be increased for late enrollment)

Program pays 80% of **REASONABLE CHARGES** (80% of **REASONABLE COSTS** when a provider—hospital, **SNF**, or **HHA**—furnishes the services) after

- Annual **DEDUCTIBLE** (amounts applied to the deductible must be the **REASONABLE CHARGES**)
- **COINSURANCE**—20% of **REASONABLE CHARGES**
- Blood deductible—first 3 pints (or equivalent units of packed red blood cells) in a calendar year (beneficiary has the option to replace this blood)

Exceptions:

- —For inpatient services of pathologists and radiologists—no deductible or coinsurance
- —For Part B home health services—deductible applies but not coinsurance
- —For outpatient physician treatment of mental illness—only 62½% of **REASONABLE CHARGES** (maximum of $312.50 per calendar year) may be allowed for benefit computation, after subtraction of any unmet deductible, the benefit is 80% of this adjusted amount
  (In effect, this limits the amount that Medicare can pay for these services to $250 in any one year)

WHAT IT COSTS

Part A—Hospital Insurance

Extended care

- **COINSURANCE** from 21st through 100th day
  —Equals 1/8 of inpatient hospital deductible

Home health services

- No **DEDUCTIBLE** or coinsurance for home health services

Note: Premiums, like deductible and coinsurance amounts, are subject to change. Premiums may change effective with July 1 of any year.

Part A—Hospital Insurance

- **PROVIDER** performs a service for a Medicare beneficiary
- Service is reviewed by a **PSRO** or an institutional **UTILIZATION REVIEW COMMITTEE** for medical necessity and appropriateness
- Provider files a claim
- Claim is processed and paid for by the **INTERMEDIARY** (or **ODR**) if certified to be medically necessary and appropriate and if all other coverage provisions are met
- Provider receives payment
- Beneficiary receives "Medicare Hospital, Extended Care, and Home Health Benefits Record," an explanation of payments made
- Provider has agreed not to charge Medicare beneficiary for covered items and services, but can bill for **DEDUCTIBLE, COINSURANCE** and noncovered items and services

(for certain noncovered items and services, **WAIVER OF LIABILITY** provisions may apply)

Part B—Medical Insurance

Two Methods of Filing

- Assignment Method
  —Must be agreed to by both the beneficiary and the physician or supplier
  —Physician or supplier files claim
  —Payment is made by the **CARRIER** directly to the physician or supplier
  —Beneficiary receives "Explanation of Medicare Benefits" (EOMB)
  —Physician or supplier agrees to accept **REASONABLE CHARGE** as full charge
  —Physician or supplier can bill the patient for no more than the unmet **DEDUCTIBLE, COINSURANCE,** and for noncovered items and services
  —For certain noncovered items and services **WAIVER OF LIABILITY** provision may apply
- Nonassignment Method
  —Beneficiary sends HCFA–1490 directly to the carrier with itemized bill (or with Part II of HCFA–1490 completed by physician)
  —Beneficiary receives EOMB and payment directly
  —Medicare payment to beneficiary is based on **REASONABLE CHARGE** but physician or supplier is not restricted to **REASONABLE CHARGE**
  —**WAIVER OF LIABILITY** provision does not apply to nonassignment method
- When a **PROVIDER** (hospital, **SNF** or **HHA**) furnishes Part B services, the provider always submits the claim

Payment is made by carrier except when a **PROVIDER** (hospital, **SNF**, or **HHA**) furnishes Part B services, payment is then made by the **INTERMEDIARY** in the same manner as outlined under Part A (see left side of this page)

HOW PAYMENT IS MADE

Part A—Hospital Insurance

A person denied Medicare benefits or in disagreement with the amount of benefits payable may appeal the decision on their claim as follows:

Issues involving benefits payable under Part A

Reconsideration
Use HCFA–2649
60 days for filing

Hearing
Use HA–501 U6
60 days for filing
Disputed amount must be $100 or more

Appeals Council Review
Use HA–520 U6
60 days for filing

Judicial Review
60 days for filing
Disputed amount must be $1,000 or more

Part B — Medical Insurance

Issues involving benefits payable under Part B

Review
Use HCFA–1964
6 months for filing

Hearing
Use HCFA–1965
6 months for filing
Disputed amount must be $100 or more

No Judicial Review provided

Issues involving Medicare entitlement or enrollment

Reconsideration
Use SSA–561 U2
60 days for filing

Hearing
Use HA–501 U5
60 days for filing

Appeals Council Review
Use HA–520 U6
60 days for filing

Judicial Review
60 days for filing

(See next page)

HOW A CLAIM IS APPEALED

HOW A CLAIM IS APPEALED

Issues involving PSRO denials of benefit payable under Parts A or B

Reconsideration

Written request within 60 days to **PSRO** which denied the claim

Any representative of the **PSRO** at the health care facility

STATEWIDE COUNCIL Review — (where applicable)

Written request within 60 days to **PSRO** which denied the claim or to **STATEWIDE COUNCIL**

Disputed amount must be $100 or more

Administrative Law Judge — (for patient only)

Written request within 60 days to either

—**PSRO** which denied the claim
—**STATEWIDE COUNCIL** (where applicable)
—Social Security District Office
—Railroad Retirement Board (where applicable)
—An Administrative Law Judge of the Office of Hearings and Appeals

Disputed amount must be $100 or more

Judicial Review

Written request within 60 days

Disputed amount must be $1,000 or more

All time limits subject to extension for "good cause"

THE ROLE OF THE SOCIAL SECURITY OFFICE

The Social Security Office

serves as a focal point for interrelationships between the beneficiary and the organizations which administer and operate the Medicare program

The Social Security Office may assist in any of the following ways:

- Establish entitlement to Hospital Insurance—Part A
- Enrollment for Medical Insurance—Part B
- Explain benefits available under Part A and Part B
- Assist beneficiaries in claiming Part A and Part B benefits
- Assist in filing claims for hospital **EMERGENCY SERVICES**
- Assist direct-dealing **PROVIDERS** in filing for Part A and Part B benefits (See **OOR**)
- Obtain correct HI claim numbers for **PROVIDERS, INTERMEDIARIES, CARRIERS,** and others
- Assist other components in resolving problems related to Part A and Part B claims
- Explain benefits paid to or on behalf of beneficiaries*
- Explain appeal rights and assist claimants in filing appeals
- Assist beneficiaries with name or address changes
- Assist beneficiaries in obtaining correct Medicare cards, and replacement of lost or stolen cards
- Assist beneficiaries with premium billing problems
- Assist beneficiaries in forwarding premiums
- Receive and refer complaints of violations of Title VI of the Civil Rights Act
- Assist in maintaining the integrity of the Medicare program by identifying potential waste and program abuse
- Promote public awareness of Medicare protection through public information programs

*Beneficiaries are encouraged to call **CARRIERS** directly on claims related matters

■ **AUTOMATIC ENROLLMENT**—The procedure whereby retirement and survivors' insurance (RSI) beneficiaries, and people entitled to disability-based benefits are sent Medicare cards three months before their first month of eligibility for hospital insurance. These Medicare cards show entitlement to both hospital insurance (HI) and supplementary medical insurance (SMI). The SMI enrollment is automatic unless declined by the beneficiary, in writing, no later than the month prior to the effective date of coverage.

—also—

People filing initial RSI claims outside their initial enrollment period (IEP), but during a general enrollment period (GEP), to establish entitlement to hospital insurance are deemed automatically enrolled in SMI during that GEP, unless they specifically decline.

—also—

People filing initial RSI claims outside their IEP or a GEP to establish entitlement to hospital insurance (often retroactive) are deemed automatically enrolled in SMI in the next GEP, unless they specifically decline.

■ **BENEFIT PERIOD**—The time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified **PROVIDER**. It ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary can have.

■ **CARRIER**—An organization which has entered into an agreement with HHS to process claims under the Medical Insurance program (Part B).

■ **COINSURANCE—GENERAL**—The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per-day dollar amount, and under Part B it is 20% of **REASONABLE CHARGES.**

■ **COINSURANCE—PART A—**
Hospital—From the 61st through the 90th day, the daily coinsurance amount is equal to 1/4 of the inpatient hospital deductible applicable for that **BENEFIT PERIOD.**

Lifetime reserve—For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to 1/2 of the inpatient hospital deductible applicable for that benefit period.

SNF—From the 21st through the 100th day, the daily coinsurance amount is equal to 1/8 of the inpatient hospital deductible applicable for that benefit period.

■ **COINSURANCE—Part B**—After the annual deductible has been met, Medicare pays 80% of **REASONABLE CHARGES** for covered services and supplies (see exceptions under What it Costs). The remaining 20% of **REASONABLE CHARGES** is the coinsurance.

■ **DEDUCTIBLES—PART A—**
Inpatient hospital deductible—An initial amount in each benefit period (reflecting the national average charge per day in a hospital) which Medicare does not pay.

Blood deductible—The first 3 pints of unreplaced blood (or equivalent units of packed red blood cells) administered in each benefit period for which Medicare does not pay.

GLOSSARY OF TERMS

GLOSSARY OF TERMS

- **DEDUCTIBLES—PART B**—The first $60 in Part B expenses which must be incurred before Medicare starts to pay. Expenses incurred in the last 3 months of a year which are applied toward the deductible for that year may also be used toward the deductible for the following year.

  There is a separate 3-pint blood deductible per calendar year under Part B which applies in the same way as the Part A blood deductible.

- **DEEMED INSURED**—This provision requires 3 quarters of coverage (QC's) whenever acquired for each year after 1966 and before the year of attainment of age 65. No QC's are needed for persons age 65 before 1968 or for **PREMIUM HI** enrollees. Note: No QC's are needed to enroll in Part B.

- **EMERGENCY SERVICES**—Hospital services which are necessary to prevent the death or serious impairment to the health of the individual, necessitating the use of the most accessible hospital equipped to furnish the services. If certain conditions are met, partial payment may be made for such services furnished by nonparticipating hospitals.

- **ENROLLMENT PERIOD**—There are two kinds of enrollment periods during which a person can voluntarily enroll for Part B, or for **PREMIUM HOSPITAL INSURANCE**:

  Initial Enrollment Period (IEP)—The 7-month period beginning 3 months before and ending 3 months after the month a person first meets all eligibility requirements. Effective date of coverage depends upon the month of enrollment.

  General Enrollment Period (GEP)—January 1 through March 31 of each year. Coverage effective July 1 of that year.

- **HEALTH MAINTENANCE ORGANIZATION (HMO)**—An entity which provides, either directly or through arrangements with others, a comprehensive range of health services to members based on a predetermined rate without regard to the frequency or extent of the services rendered.

- **HOME HEALTH AGENCY (HHA)**—An agency meeting certain requirements which provides health care in the home (see **PARTICIPATING**). Among services provided are part-time skilled nursing care and physical, occupational or speech therapy. Coverage is available under both Part A and Part B.

- **INTERMEDIARY**—An organization which has entered into an agreement with HHS to process Medicare claims from hospitals, **SKILLED NURSING FACILITIES**, and **HOME HEALTH AGENCIES** under Part A.

- **LEVEL OF CARE**—To qualify for Medicare benefits for inpatient hospital, **SKILLED NURSING FACILITY**, or home health services, a beneficiary must both need and receive a certain type and degree of health care (i.e., a certain "level of care"). This "level of care" will vary among the 3 types of providers (hospitals, **SNFs** and **HHAs**). For Medicare reimbursement to be made, both the type of **PROVIDER** and the care provided to the beneficiary must be appropriate to the beneficiary's medical needs.

- **LIFETIME RESERVE**—Additional days of inpatient hospital care the beneficiary may draw upon after 90 days in a **BENEFIT PERIOD** have been used. Reserve days used cannot exceed 60 during a beneficiary's lifetime.

- **ODR**—Office of Direct Reimbursement, Bureau of Support Services, Health Care Financing Administration—Acts as an intermediary for **PROVIDERS** who elect to deal directly with the Federal government.

- **PARTICIPATING**—To participate in the Medicare program, **PROVIDERS** must meet certain standards which help assure that they will be able to provide acceptable health care, and they must enter into a formal agreement with the Federal government. In general, payments are made only to **PROVIDERS** who are participating in the Medicare program.

- **PREMIUM HI**—Hospital insurance obtainable by timely application and payment of a monthly premium by individuals age 65 and older not otherwise eligible for HI (effective 7/1/73).

- **PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO)**—A local physician organization established under the Social Security Act to review health care provided to patients under the Medicare and Medicaid programs and to make determinations on the medical necessity, quality, and appropriateness of care.

- **PROVIDER**—An institution or agency which provides health care services. Hospitals, skilled nursing facilities (**SNFs**), and home health agencies (**HHAs**) are the major providers.

- **REASONABLE CHARGE**—An individual charge determination made by a **CARRIER** for a covered Part B medical service or supply. In the absence of unusual medical circumstances it is the lowest of: (1) the physician's or supplier's customary charge for that service, (2) the prevailing charge for similar services in the locality, (3) the actual charge made by the physician or supplier, and (4) the carrier's private business charge for a comparable service.

- **REASONABLE COST**—The basis for payments to **PARTICIPATING PROVIDERS**. Reimbursement is based on the reasonable cost of providing services or the customary charges for such services, whichever is less.

- **RURAL HEALTH CLINIC (RHC)**—A **PROVIDER** based or independent facility located in a rural, medically underserved area. It meets certain certification requirements and provides outpatient primary medical care through physicians, physician assistants, nurse practitioners and nurse midwives under the general supervision of a physician.

- **SNF**—Skilled Nursing Facility—An institution such as a skilled nursing home or rehabilitation center. It is designed for the patient who no longer needs the intensive care of a hospital but who still needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which inpatient hospital services were received and which—as a practical matter—can only be provided in a SNF on an inpatient basis. To be certified as a SNF, the institution must meet certain conditions (see **PARTICIPATING**).

- **STATE BUY-IN AGREEMENT**—A statutory procedure whereby States may enroll certain welfare beneficiaries for Part B and pay their premiums.

- **STATEWIDE COUNCIL**—A Statewide Professional Standards Review Council.

- **UTILIZATION REVIEW COMMITTEE**—The hospital committee responsible for reviewing health care services provided Federally funded patients in those areas where a **PSRO** has not assumed review.

- **WAIVER OF LIABILITY**—A provision of Medicare which grants relief to a beneficiary who acted in good faith in accepting services, believing them to be covered by Medicare and finding later that they are not—for one of two reasons: either the services are determined not to be "reasonable and necessary" or they are determined to constitute "custodial care". The beneficiary may not be held liable for payment of these services (except for deductible or coinsurance amounts) if the beneficiary did not know (and could not reasonably be expected to have known) that the services provided were not covered. The Medicare program itself will assume liability if neither the beneficiary nor the provider knew (or could reasonably be expected to have known) that the services were not covered. (Does not apply to unassigned claims under Part B.)

GLOSSARY OF TERMS

Comments on a Guide to Medicare

As a user of this booklet, your opinion on the following is solicited.

1 In what way did you find the booklet useful?

2 How would you improve the booklet?

3 What Medicare topics would you suggest for similar publications?

4 What is your organization and position?

Address comments to:

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Additional copies of this booklet can be obtained by contacting your servicing Health Care Financing Administration (HCFA) Regional Office or by writing to Health Care Financing Administration, Office of Management and Budget, Office of Human Resources and Administrative Services, D-3, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235

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